MDR Tracking Number: M5-05-1949-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-14-05.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review:
3-3-04 through 3-9-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO reviewed office visits, manual therapy technique, electrical stimulation, therapeutic exercises, neuromuscular re-education for 3-17-04 through 6-14-04 that were denied by the insurance carrier for medical necessity.

The office visits, manual therapy technique, electrical stimulation, therapeutic exercises and neuromuscular re-education for 3-17-04 through 6-14-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is $4,157.27.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-6-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT code 99212 on 6-9-04: The EOB states that this service was paid by the carrier. MDR was unable to verify this with the requestor. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Recommend reimbursement of $45.41.**

This Decision and Order is hereby issued this 10th day of June 2005.

Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling $4,202.68 from 3-17-04

through 6-14-04 outlined above as follows: In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is hereby issued this 10th day of June 2005.

Manager, Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

May 26, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1949-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1978. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 40 year-old male injured his left arm on ___ when an I-beam fell on his arm crushing it between the beam and a block. The diagnosis was crush injury that later was changed to include fracture. He was treated with surgery, medications, and therapy.

Requested Service(s)

Office visit, manual therapy technique, electrical stimulation, therapeutic exercises, neuromuscular re-education for dates of service 03/17/04 through 06/14/04

Decision

It is determined that there is medical necessity for the office visit, manual therapy technique, electrical stimulation, therapeutic exercises, and neuromuscular re-education for dates of service 03/17/04 through 06/14/04 to treat this patient's medical condition.

Rationale/Basis for Decision

This patient has suffered a crush injury to his left arm. He continues to show an abnormal Electromyogram; however, his progression is predictable and improving. Recovery from this type of injury is slow due to the neuromuscular component of the injury. Therefore, the office visits, manual therapy technique, electrical stimulation, therapeutic exercises, and neuromuscular re-education for dates of service 03/17/04 through 06/14/04 are medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

**Attachment**

**Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M5-05-1949-01**

**Information Submitted by Requestor:**

- Progress Notes
- Designated Doctors Evaluation
- Work Hardening
- Diagnostic Tests
- Claims/Disputes
- Request's Position

**Information Submitted by Respondent:**

- Progress Notes
- Claims